Document generated on 12/21/2024 12:52 p.m.

Canadian Medical Education Journal
Revue canadienne de l'éducation médicale

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Volume 15, Number 4, 2024

URI: https://id.erudit.org/iderudit/1113589ar
DOI: https://doi.org/10.36834/cmej.79935

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Publisher(s)

Canadian Medical Education Journal

ISSN

1923-1202 (digital)

Explore this journal

Cite this document

D’Eon, M. (2024). Emotional labour in learning to doctor. *Canadian Medical Education Journal / Revue canadienne de l'éducation médicale*, *15*(4), 1–4. https://doi.org/10.36834/cmej.79935

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Canadian Medical Education Journal

Editorial

Emotional labour in learning to doctor

Le travail émotionnel dans l'apprentissage de la médecine

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Published: Aug 30, 2024. CMEJ 2024, 15(4) Available at https://doi.org/10.36834/cmej.79935
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The emotional work of health care is often ignored or insufficiently addressed in medical schools and residency programs. The title image of this issue, by Zieneldien and Kim,[1] highlights the emotional labour of medical students associated with their journey. It inspired me to consider the topic more broadly.

Emotional work refers to the time and effort spent managing our own emotions while recognizing and caring for the emotions of others.[2] The emotional labour of health care is connected to communication skills and styles, especially when focused on others. A simple phrase like, "I'm sorry for your loss," can carry more meaning and healing if they are heartfelt rather than rapidly sandwiched among probing questions about the patient's present complaint. Patient outcomes are affected by our words and behaviours[3] and may also incur iatrogenic suffering among trainees.[4,5] The gendered culture of detached concern is not serving us well.

Medical students and residents need to deal with their own life circumstances, the gruelling work of learning to become a doctor,[6] in addition to responding personally and professionally to death, disability, and dysfunction of patients with their families. Asking medical students to interact more with the patients and families gives the hidden message that the hard work of managing emotions and communicating empathetically belongs to underlings and not to residents or attending physicians (who have more "important" tasks on their plates). Communicating and working in emotional situations takes skill, intelligence, and considerable effort. There is a lot to navigate on these stormy waters,[7] and our learners are largely unprepared.

We can and should ensure that learners are intellectually and emotionally equipped for their work. Communication skills and emotional intelligence can be learned[8]—though it takes time and energy. What we often label as "soft skills" are truly challenging for those who have bypassed or were not offered this aspect of training. And all the while, there are powerful social and organizational factors, not just technological ones, that bring negative changes in empathy among trainees and professionals alike.[8,9] Sheikh makes several recommendations to address this situation, such as more experiences with patients and high-quality instruction which to me means including practice, simulations, role plays, and coaching.[8]

We need to recognize the importance of emotional labour in the lives of our medical trainees and then act to form and educate them how to better manage these situations for the benefit of patients and the trainees themselves.

Similarly, the articles in this issue will contribute to better understanding and then improving medical education.

Original Research

A phenomenological study of resident and faculty experiences with learner engagement in the normalization of workplace-based assessment by Melissa Mc Donald and Fiona Muir[10] highlighted the importance of learner engagement in Workplace-Based Assessments by involving residents and faculty at all stages of its development and implementation.

Agentivité : perspectives des ergothérapeutes quant à leur sentiment de compétence et quant à leurs compétences à la suite d'une formation by Carrier and team[11] documented occupational therapists' perceptions of their skills before

and after agency training. Their results showed an improved sense of competence, particularly in communication and intentional collaboration. However, they still felt unprepared to exercise these skills in real-life contexts. This is a French article.

Fernandez and Gulino's study, An activity theory perspective on interprofessional teamwork in long-term care,[12] used video analysis to explore how healthcare teams work together and adapt to challenges in a long-term care setting. They found that teamwork often involved being flexible with roles and continuous adaptation.

Experiences of racism of Black medical students and residents in Montréal: "I wear my stethoscope around my neck at all times" by Soares and co-authors[13] used Critical Race Theory to document and analyze the experiences of racism faced by Black medical students and residents. Their study revealed that the students and residents encountered microaggressions in both academic and clinical settings.

Brief Reports

Jessica Trier and team's study, Is Competency-Based Medical Education being implemented as intended? Early lessons learned from Physical Medicine and Rehabilitation,[14] evaluated the early outcomes of implementing competency-based medical education. They stressed the importance of early program evaluation to identify gaps between intended and actual outcomes.

When medical students are autonomously motivated to mentor: a pilot study on confidence in clinical teaching and psychological well-being by Nair and team[15] explored how near-peer mentorship (NPM) programs affect medical students' well-being and clinical teaching skills. They found that self-motivated students felt more competent in teaching.

Reviews, Theoretical Papers, and Meta-Analyses

Patricia Blanchette and team's article, Making judgments based on reported observations of trainee performance: a scoping review in Health Professions Education,[16] examined how reported observations are used in assessing trainee performance. They outlined six steps in the process, including making first contact. The authors emphasized the significance of designing assessments based on reported observations to ensure the quality of graduates in Health Professions Education.

The state of wellbeing education across North American medical schools: a scoping review by Raiter et al.[17] explored how North American medical schools address student burnout. They identified mindfulness and meditation practices as common interventions and suggested that a structured wellbeing curriculum could improve student outcomes within medical education.

In Sexual and gender minority health: a roadmap for developing evidence-based medical school curricula by Catherine Giffin et al.,[18] the authors conducted a scoping literature review to identify best practices for teaching sexual and gender minority (SGM) health in undergraduate medical education across Canada. Based on the findings, they developed eight propositions to standardize SGM education nationally, including setting common learning objectives and involving the local SGM community in curriculum development.

Canadiana

Celebrating inquiry and scholarship: the inaugural Canadian Medical Student Research Competition by Amrit Kirpalani[19] outlined the background, development, and outcomes of the inaugural Canadian Medical Student Research Competition (CMSRC). The event provided a platform for showcasing medical student research achievements.

Kazevman's piece, Hiding in Canadian medicine[20] described the author's experience and increasing concern with antisemitism in medical Education.

You Should Try This!

Patient safety: a flipped classroom curriculum for family medicine residents by Jattan and Suss[21] described an engaging learning activity to improve patient safety training within the family medicine curriculum using a flipped classroom approach.

Herod and team's article, Thriving Together: a novel workshop to improve cohesion and class culture in medical school cohorts,[22] described their first-year medical student workshop intended to promote communication, empathy, and relationship-building among classmates.

Practice makes perfect: the development of a medical student-led crowdsourced question bank for self-study in undergraduate medical education by Corrado and co-authors[23] introduced a student-led, bilingual study resource tailored to the University of Ottawa's undergraduate medical education curriculum. Their platform aimed to provide a cost-effective study resource

by involving students in developing multiple choice questions.

A novel IDEA(-R) for a small group teaching format by Preti and Sanatani[24] presented a new small group teaching format called IDEA-R (Individual answer, Discussion, Expanded discussion, Advancement of Case, Rearrangement) that was designed to target and escalate cognitive learning tasks effectively.

Commentary and Opinions

In Psychedelics in medicine - a call for educational action by Shane, Co, and team,[25] the authors contended that normalizing discussions on the use of psychedelics will reduce stigma and help keep up with medical research so future clinicians can practice and teach effectively.

In the commentary, Standards and accountabilities for professional resistance by Ellaway and Orkin,[26] the authors contended that the lack of professional resistance standards is a growing problem in Canada. They argue for clear standards and accountability for Canadian health professionals.

In Why we must incorporate *primum non nocere* into assessment reappraisal, Desy and co-authors[27] emphasized the principle of 'first, do no harm' in academic assessment reappraisal. The authors suggested prioritizing the prevention of psychological trauma by providing necessary support and voiding original decisions when needed.

Evolving, not maintaining: embracing the dynamic nature of physician competence by Bellemare and team[28] proposed replacing the term "Maintenance of Certification" (MOC) with "Evolution of Competence" (EOC) to better reflect the dynamic and evolving nature of medical practice and physician development.

In their commentary, Northern exposure: reflections on a transformative family medicine rotation in Rural Ontario,[29] Land and Mercier reflected on the experience in rural rotation in Northern Ontario. They maintained that it provided an unmatched opportunity to gain experience and refine skills.

Letters to the Editor

The art of Robert Pope by Shankar[30] is a letter responding to Huang and Kam's previously published article, Humanism in Canadian medicine: from the Rockies to the Atlantic.[31] Shankar uses the art of the late Canadian artist Robert Pope as an example of Canada's strength in medical humanities.

In their previously published letter,[32] Wiwanitkit and Wiwanitkit commented on Han et al.'s study,[33] suggesting improvements by addressing limitations such as low response rates, a larger sample size, and longer study duration. In Ongoing discussions on supporting medical students during a crisis,[34] Han and Nyhof-Young responded, acknowledging these suggestions but explaining that, given the urgency of the pandemic, they prioritized timely insights for the MD program over extending the study further.

Enjoy!

Marcel D'Eon
CMEJ Editor-in-Chief

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